

2009 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB207)

Received: 10/06/2009

Received By: **tdodge**

Wanted: As time permits

Identical to LRB:

For: **Chuck Benedict (608) 266-9967**

By/Representing: **Tara Vasby**

This file may be shown to any legislator: **NO**

Drafter: **tdodge**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous
Insurance - health**

Extra Copies: **PJK**

Submit via email: **YES**

Requester's email: **Rep.Benedict@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Requiring that patients be informed of health care facility use charges, requiring identification of the facility use charges, requiring disclosure of coverage by insurance companies

Instructions:

See attached.

Drafting History:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
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FE Sent For:

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/?	tdodge	1/19 09	10 19 PH				

FE Sent For:

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**ASSEMBLY SUBSTITUTE AMENDMENT ,
TO 2009 ASSEMBLY BILL 207**

1 **AN ACT** *to create* 146.97, 609.895 and 632.792 of the statutes; **relating to:** requiring
2 that patients be informed of health care facility use charges and that the charges be
3 identified, and insurance coverage of charges.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

4 **SECTION 1.** 146.97 of the statutes is created to read:

5 **146.97 Health care facility use charges. (1)** In this section:

6 (a) "Clinic" means a place that is used primarily for the provision of services of a health
7 care provider.

8 (b) "Good faith estimate of the facility use charge" means an estimate, made in good
9 faith by a health care facility or a health care provider, that is expressed as one of the following:

10 1. A specific dollar amount.

11 2. A range that includes at least 80% of the health facility's or health care provider's
12 use charges over a 12-month period that ended within 6 months prior to the date of the
13 estimate.

14 (c) "Health care facility" has the meaning given in s. 146.997 (1) (c) and also includes
15 a clinic and an ambulatory surgery center, as defined in s. 153.01 (1g).

16 (d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

1 (2) If a health care facility or a health care provider itemizes a billing charge for use of
2 the health care facility during a patient's office visit with a health care provider, the health care
3 facility or health care provider shall do all of the following:

4 (a) At the time the appointment is made, notify the patient orally that the health care
5 facility use charge will be imposed and that the patient should check with his or her insurer
6 to determine whether the insurer covers that charge.

7 (b) By the end of the next business day after the appointment is made, provide the patient
8 with a good faith estimate of the facility use charge. An estimate that is placed in the mail by
9 the end of the next business day satisfies this paragraph.

10 (c) Identify in the bill the health care facility use charge as a "facility fee."

11 (3) A good faith estimate under this section is not legally binding on the facility or
12 provider.

13 **SECTION 2.** 609.895 of the statutes is created to read:

14 **609.895 Disclosure of facility use charge coverage.** Limited service health
15 organizations, preferred provider plans, and defined network plans are subject to s. 632.792.

16 **SECTION 3.** 632.792 of the statutes is created to read:

17 **632.792 Disclosure of facility use charge coverage. (1) DEFINITIONS.** In this section:

18 (a) "Facility use charge" means a billing charge for use of a health care facility as
19 described in s. 146.97 (2) (intro.).

20 (b) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

21 (c) "Self-insured health plan" has the meaning given in s. 632.85 (1) (c).

22 **(2) REQUIRED DISCLOSURE.** A health care plan or a self-insured health plan shall include
23 disclosure of all of the following in any agreement, policy, or certificate of coverage:

24 (a) Whether the plan covers facility use charges.

1 (b) The extent of, and limitations on, coverage of facility use charges.

2 (c) Whether a patient's payment for all or part of a facility use charge counts toward
3 satisfying any deductible amount under the plan.

4 **SECTION 4. Initial applicability.** The treatment of sections 609.895 and 632.792 of the
5 statutes first applies to all of the following:

6 (a) Except as provided in paragraphs (b) and (c), disability insurance policies that are
7 issued or renewed, and self-insured governmental or school district health plans that are
8 established, extended, modified, or renewed, on the effective date of this section.

9 (b) Disability insurance policies covering employees who are affected by a collective
10 bargaining agreement containing provisions inconsistent with this act that are issued or
11 renewed on the earlier of the following:

12 1. The day on which the collective bargaining agreement expires.

13 2. The day on which the collective bargaining agreement is extended, modified, or
14 renewed.

15 (c) Self-insured governmental or school district health plans covering employees who
16 are affected by a collective bargaining agreement containing provisions inconsistent with this
17 act that are established, extended, modified, or renewed on the earlier of the following:

18 1. The day on which the collective bargaining agreement expires.

19 2. The day on which the collective bargaining agreement is extended, modified, or
20 renewed.

21 **SECTION 5. Effective dates.** This act takes effect on the day after publication, except
22 as follows:

(1) The treatment of sections 609.895 and 632.792 of the statutes and SECTION 4 of this act takes effect on January 1, 2011.

3 (END)

Dodge, Tamara

From: Vasby, Tara
Sent: Tuesday, October 06, 2009 12:23 PM
To: Dodge, Tamara
Subject: RE: Substitute Amendment to AB207

Attachments: 0436/3

Tamara,
We've been working with Dick Sweet and a number of stakeholders to get a solid Substitute amendment drafted for AB207. Could you please draft the attached Leg Council draft as the sub to AB207? The bill/sub will have a hearing on November 17th.

Thanks!
Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

LRB 1110/4

From: Learned, Julie
Sent: Tuesday, October 06, 2009 9:48 AM
To: Vasby, Tara
Subject: Memorandum and bill draft from Richard Sweet, Legislative Council



04363.pdf (12 KB)

Julie Learned
Legislative Council Staff
One East Main St., Suite 401
(608) 266-2985

Dodge, Tamara

From: Vasby, Tara
Sent: Monday, October 12, 2009 9:58 AM
To: Dodge, Tamara
Subject: RE: Substitute Amendment to AB207

Yes, I believe that is what we would like to have done. Make sure that an explanation of facility fees is included in everyone's policy.

From: Dodge, Tamara
Sent: Monday, October 12, 2009 9:57 AM
To: Vasby, Tara
Subject: RE: Substitute Amendment to AB207

Tara,

I had a question on this substitute amendment. The submitted language uses different definitions and inserts the language in fewer places than we typically do when requiring insurance policies and plans to cover or do something. Do you want every possible type of health insurance policy and health plan that OCI can regulate to provide the disclosure regarding the facility fee?

If so, I will just conform the substitute amendment to our typical format.

Thanks.
Tami

Tamara J. Dodge

Attorney
Wisconsin Legislative Reference Bureau
P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Vasby, Tara
Sent: Tuesday, October 06, 2009 12:23 PM
To: Dodge, Tamara
Subject: RE: Substitute Amendment to AB207

Tamara,
We've been working with Dick Sweet and a number of stakeholders to get a solid Substitute amendment drafted for AB207. Could you please draft the attached Leg Council draft as the sub to AB207? The bill/sub will have a hearing on November 17th.

Thanks!
Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

From: Learned, Julie
Sent: Tuesday, October 06, 2009 9:48 AM
To: Vasby, Tara
Subject: Memorandum and bill draft from Richard Sweet, Legislative Council

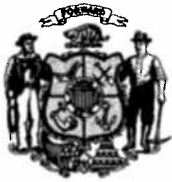
<< File: 0436/3 >>

Julie Learned

Legislative Council Staff

One East Main St., Suite 401

(608) 266-2985



State of Wisconsin
2009 - 2010 LEGISLATURE

LRBs0144001

TJD:.....

In: 10/13/09

RMNR

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PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION
ASSEMBLY SUBSTITUTE AMENDMENT ,
TO 2009 ASSEMBLY BILL 207

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- 1 AN ACT ~~relating to~~ requiring that patients be informed of health care facility
2 use charge and that charge be identified and requiring disclosure of insurance
3 coverage of facility use charge.

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care facility or health care provider that itemizes a charge for use of the facility to notify a patient, orally at the time the appointment is made, that it will impose the facility use charge. Before the end of the next business day after the appointment is made, the health care facility or health care provider must provide the patient with a good faith estimate of the facility use charge. This estimate must be expressed either as a specific dollar amount or as a range that includes at least 80% of the health care facility's or health care provider's facility use charge over a 12-month period that ended within 6 months before the date of the estimate. The health care facility or health care provider, on any bill imposing the charge, must identify the facility use charge as a "facility fee" but may charge a facility use charge different from the amount given in the good faith estimate.

This substitute amendment also requires health insurance policies and self-insured governmental and school district health plans in an agreement, policy

Beginning on January 1, 2011, this

in a policy, plan, or certificate of coverage

or certificate of coverage, to disclose all of the following regarding the facility use charge: whether the policy or plan covers a health care facility use charge and to what extent the charge is covered, whether the policy or plan imposes limitations on the coverage of the facility use charge, and whether a patient's payment of all or part of the facility use charge counts toward any deductible under the policy or plan. The disclosure requirement applies to individual and group health insurance policies, including limited service health organizations, preferred provider plans, defined network plans, and cooperative sickness care associations; to health care plans, including a self-insured plan, offered by the state to its employees; and to self-insured health plans of a city, town, village, county, or school district.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 (8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

NOTE: NOTE: Sub. (8) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, ~~632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5), 632.87 (3) to (6), 632.895 (5m) and (8) to (15), and 632.896.~~

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 (8m) Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (17).

NOTE: NOTE: Sub. (8m) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads: NOTE:

(8m) Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, ~~632.85, 632.853, 632.855, and 632.895 (11) to (15).~~

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

NOTE: NOTE: Sub. (4) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (15), 632.896, and 767.25 (4m) (d) [s. 767.513 (4)].

History: 1999 a. 9, 115; 1999 a. 150 ss. 34, 303 to 306; Stats. 1999 s. 66.0137; 1999 a. 186 s. 63; 2001 a. 16, 30; 2005 a. 194; 2005 a. 443 s. 265; 2007 a. 20, 36; 2009 a. 14, 28.

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

NOTE: NOTE: Par. (g) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (15), 632.896, and 767.25 (4m) (d) [s. 767.513 (4)].

History: 1973 c. 94, 290; 1973 c. 115, 321; 1977 c. 206, 211, 418, 429; 1979 c. 20, 202, 221, 301, 355; 1981 c. 96, 314, 335; 1983 a. 27, 193, 207, 339, 370, 518, 538; 1985 a. 29 ss. 1725e to 1726m, 1731; 1985 a. 101, 135, 211; 1985 a. 218 ss. 12, 13, 22; 1985 a. 332; 1987 a. 88, 187; 1989 a. 31, 201, 336, 359; 1991 a. 39, 226, 269; 1993 a. 16, 27, 284, 334, 399, 450, 481, 491; 1995 a. 27 ss. 4024, 9126 (19), 9145 (1); 1995 a. 29, 32, 33, 65, 75, 225, 235, 289, 439; 1997 a. 27, 155, 164, 191, 237, 335; 1999 a. 9, 19, 73, 83, 115, 128; 1999 a. 150 s. 672; 1999 a. 186; 2001 a. 38, 98, 103, 105; 2003 a. 254; 2005 a. 22, 194, 290, 346; 2005 a. 443 s. 265; 2007 a. 20 ss. 2738, 9121 (6) (a); 2007 a. 36, 70, 97; 2009 a. 14, 28.

SECTION 5. 146.97 of the statutes is created to read:

146.97 Health care facility use charges. (1) In this section:

(a) "Clinic" means a place that is used primarily for the provision of services of a health care provider.

(b) "Good faith estimate of the facility use charge" means an estimate, made in good faith by a health care facility or a health care provider.

(b)
(c) "Health care facility" has the meaning given in s. 146.997 (1) (c) and includes a clinic and an ambulatory surgery center, as defined in s. 153.01 (1g).

(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(2) If a health care facility or a health care provider itemizes a billing charge for use of the health care facility during a patient's office visit with a health care provider, the health care facility or health care provider shall do all of the following:

(a) At the time the appointment is made, notify the patient orally that the health care facility use charge will be imposed and that the patient should check with his or her insurer to determine whether the insurer covers that charge.

(b) Before the end of the next business day after the appointment is made, provide the patient with a good faith estimate of the facility use charge either as a specific dollar amount or as a dollar range that includes at least 80% of the health care facility's or health care provider's facility use charges over a 12-month period that ended within 6 months before the date of the estimate. An estimate that is placed in the mail before the end of the next business day satisfies this paragraph.

(c) Identify in the bill the health care facility use charge as a "facility fee."

(3) The facility or the provider may charge to the patient an actual facility use charge that is different from the good faith estimate of the facility use charge under sub. (2) (b).

SECTION 6. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.981 (4t) A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.792, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (10) to (17), and 632.897 (10) and chs. 149 and 155.

is provided
within the time
required under

NOTE: NOTE: NOTE: Sub. (4t) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(4t) A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

History: 1971 c. 40 s. 93; 1971 c. 307 s. 118; 1975 c. 98; 1975 c. 223 s. 28; 1975 c. 224 s. 146; 1975 c. 421; 1981 c. 39 s. 22; 1981 c. 205; 1981 c. 391 s. 210; 1985 a. 29; 1985 a. 30 s. 42; 1987 a. 27 ss. 1917e, 3202 (47) (a); 1987 a. 312 s. 17; 1989 a. 121, 129, 200, 201, 336; 1991 a. 39, 123, 269; 1993 a. 27, 450, 481; 1995 a. 27, 118, 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin

Act 28, is amended to read:

185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.792, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (5) and (9) to (17), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

NOTE: NOTE: Sub. (1) (intro.) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets. NOTE:

(1) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

History: 1975 c. 98; 1975 c. 224 s. 146; 1975 c. 352; 1975 c. 422 s. 163; 1977 c. 339; 1979 c. 89; 1981 c. 20; 1981 c. 39 s. 22; 1981 c. 82; 1981 c. 391 s. 210; 1983 a. 189 s. 329 (25); 1983 a. 396; 1985 a. 29 ss. 2060d to 2060r, 3202 (30); 1987 a. 27, 325; 1989 a. 23, 31, 129, 200, 201, 336, 359; 1991 a. 39, 189, 250, 269, 315; 1993 a. 450, 481, 482; 1995 a. 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 8. 609.895 of the statutes is created to read:

609.895 Disclosure of facility use charge coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.792.

SECTION 9. 632.792 of the statutes is created to read:

632.792 Disclosure of facility use charge coverage. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Health care facility" has the meaning given in s. 146.97 (c).

(1)(b)

(c) "Health care facility use charge" means an itemized billing charge from a health care facility or health care provider for use of the health care facility during a patient's office visit with a health care provider.

(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(e) "Self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) REQUIRED DISCLOSURE. Every disability insurance policy and every self-insured health plan shall disclose of all of the following in any agreement, policy, or certificate of coverage:

(a) Whether the policy or plan covers a health care facility use charge.

(b) The extent of, and limitations on, coverage of a health care facility use charge.

(c) Whether a patient's payment for all or part of a health care facility use charge counts toward satisfying any deductible amount under the policy or plan.

SECTION 10. Initial applicability.

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 11. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (n), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes and SECTION 4 of this act takes effect on January 1, 2011.

(END)

use
auto reb
(A)
from p. 6